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Firth H, Todd A, Bambra C. Benefits and barriers to the public health pharmacy: a qualitative exploration of providers' and commissioners' perceptions of the Healthy Living Pharmacy Framework. *Perspectives in Public Health* 2015, 135(5), 251-256.

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DOI link to article:

http://dx.doi.org/10.1177/1757913915579457

Date deposited:

10/02/2017

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Benefits and Barriers to the Public Health Pharmacy: A qualitative exploration of providers' and commissioners' perceptions of the Healthy Living Pharmacy Framework

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Abstract

Aims: The aims of this study were to explore the barriers to the implementation and progression of the Healthy Living Pharmacy (HLP) framework, from both provider and commissioner perspectives, and to ascertain whether the successes and barriers of the framework perceived by pharmacies are shared with commissioners.

Methods: A structured qualitative interview study, using purposive sampling, was undertaken with 11 community pharmacists and 11 Healthy Living Champions (providers) from HLPs in the North of England. Four commissioners of such services were also interviewed. Interviews were analysed using a thematic approach.

Results: There were many aspects of the HLP framework that the service 'providers' were positive about namely: workforce development, engagement (particularly with the smoking cessation service), and as a motivation for pharmacy teams. However, there were areas of concern about low awareness amongst pharmacy users, the time involved in delivery, as well as financial considerations. These were exemplified by the health checks element. Commissioners also expressed concerns about health checks as well as a lack of cohesion between commissioners and service providers and a poor understanding of the broader framework.

Conclusion: The HLP framework was perceived as valuable by providers although there were areas of concern. A key barrier to the framework – perceived by both providers and commissioners – was the implementation of health checks. This should be considered in future commissioning.

Introduction

Community pharmacies have emerged in recent years as strategically important settings with great potential for delivering public health services. One advantage of community pharmacies compared to other healthcare providers is the reach into the population: an estimated 90 per cent of the population make at least one visit per year,[1] suggesting they have the potential to not only target patients with long-term conditions, but also those who do not interact with other healthcare professionals. Crucially, in England, it has been shown that the distribution of community pharmacies are positively associated with areas of high deprivation – a so-called positive pharmacy care law.[2] Community pharmacies, therefore, are ideally placed in the community to meet healthcare needs of the population and, potentially – through targeting patients that need healthcare the most – reducing certain health inequalities. This potential has been acknowledged: for example, the White Paper, *Pharmacy in England: building on strengths, delivering the future*, details how community pharmacists could play a greater role in delivering public health services.[3] One idea was that community pharmacies could act as 'healthy living' centres, providing greater services to the local needs of the population.

In view of this, there is now significant emphasis placed upon community pharmacies delivering patient-focused services, including promoting healthy lifestyles and modification of health-related behaviours, as well as providing medicine-related activities. This change has been supported through the contractual framework for community pharmacy in England, which allows community pharmacists to deliver a range of patient-focused healthcare services.[4] These include: offering treatments for minor ailments, providing support to patients with long-term conditions, offering

screening for individuals with high risk of vascular disease, and providing commissioned services based on the needs and health risks of the local population they serve.

Building on the success of the community pharmacy contractual framework and the 'healthy living' centre approach discussed in the White Paper, the Healthy Living Pharmacy (HLP) framework was established, which allows community pharmacies to deliver a portfolio of public health services tailored according to local need.[5,6] The framework is designed around a tiered commissioning system with three levels, each delivering an increasingly sophisticated suite of services.[7] The overarching themes of the different tiers of service are: health promotion (Level 1), health prevention (Level 2) and health protection (Level 3). Services are thus commissioned according to these activities with smoking, alcohol and weight management key areas of focus. To support the transformation from a community pharmacy to a HLP, there are three 'enablers' that underpin the three levels of service. These are: workforce development and Healthy Living Champions (HLCs) (members of the pharmacy team who have undertaken specific additional training), on site premises fit for the delivery of the service, and engagement with other stakeholders (e.g. GPs, social care and public health professionals).

At present, research suggests that HLPs have the potential of improving the health of some patient groups compared to non-HLPs.[8] However, despite an understanding around barriers associated with implementation, there is little known about the challenges associated with progressing between levels of the framework (notably from Level 1 to 2) or the views of commissioners responsible for commissioning

these services. The aim of this study was, therefore, to explore the barriers to the implementation and progression of the HLP framework, from both pharmacy and commissioner perspectives, and to ascertain whether the successes and barriers of the framework perceived by pharmacies are shared with commissioners.

Methods

A structured qualitative interview study was undertaken with the following participants based in the North of England:

- Community pharmacists working in Healthy Living Pharmacies
- Healthy Living Champions working in Healthy Living Pharmacies
- Commissioners who were responsible for commissioning services from Healthy Living Pharmacies

For the purposes of the study, a community pharmacist was defined as a registrant of the General Pharmaceutical Council, a Health Living Champion was defined as a member of the pharmacy team with a Level 2 qualification in Understanding Health Improvement, as accredited by the Royal Society for Public Health (RSPH), while a commissioner was defined as an individual working within the Local Authority with responsibility for commissioning services from HLPs.

Participants from HLPs (pharmacists or HLCs) were purposively sampled, according to the ward-level unemployment data as a proxy for relative deprivation of the community pharmacy[9] and, if they were progressing to the next tier of the framework. Community pharmacies in areas with unemployment of under 6 per cent were classified as low deprivation, unemployment between 6 and 10 per cent as medium deprivation, and unemployment over 10 per cent as high deprivation. Commissioners

were sampled according to their specific area of responsibility (*e.g.* smoking, alcohol or weight management).

Among the 22 HLPs in the study region, interviews were carried out at 11: five in those progressing to Level 2 and six in those remaining at Level 1 (Table 1). In each HLP, a pharmacist and HLC were interviewed.

Table 1: Code names for pharmacies where interviews were carried out, showing ward level per cent unemployment as a proxy for deprivation

Pharmacy code	**Deprivation level**	**Ward level % unemployed**	**Progressing to Level 2?**
Pharmacy 1	Low	5.9	Yes
Pharmacy 2	Low	4.8	No
Pharmacy 3	Low	5.4	No
Pharmacy 4	Low	5.9	No
Pharmacy 5	Medium	8.3	Yes
Pharmacy 6	Medium	9.4	Yes
Pharmacy 7	Medium	6.6	No
Pharmacy 8	Medium	7.1	No
Pharmacy 9	High	12.1	Yes
Pharmacy 10	High	12.3	Yes
Pharmacy 11	High	11.5	No

Interviews were also conducted with four members of a Local Authority responsible for commissioning the HLP framework; specifically, the heads of the smoking cessation, weight management, substance misuse and health checks aspects of the framework. These four individuals were selected as smoking, alcohol use and obesity are the three most significant social determinants of health, and the health checks comprise a major aspect of the framework. Data collection took place between May and August 2014.

A structured-interview approach was adopted, to ensure that each respondent was asked exactly the same questions, keeping to the same wording for each interview. This consistency minimised error, as even small changes to wording can exert impact on responses.[10] The interview schedule was developed after informal meetings with community pharmacists working in HLPs, and commissioners. The interview questions were then piloted with one commissioner and two community pharmacists and, based on feedback modified for the main set of interviews. The interview questions for community pharmacists and HLCs are outlined in Box 1 and those for commissioners in Box 2.

Box 1: Interview questions for community pharmacists and HLCs

1. What were your expectations when you decided to become a HLP?
2. Can you describe the impact on your pharmacy brought about by the HLP framework?
3. Are there any aspects of the framework you consider to have been a success/what are the strengths to the framework?
4. Are there any aspects of the framework you consider to be barriers to its success/what has been most challenging?
5. As a pharmacy you are progressing on the framework from L1 to L2; could you outline your reasons for this decision? or
6. As a pharmacy, having achieved L1 you are not progressing on the framework to L2; could you outline your reasons for this decision?
7. How have you found it delivering the health checks?
8. Has there been any feedback from your clients about the HLP?
9. As the HLP scheme is new, did you feel you had enough support in implementing the framework?
10. Is there anything you would like to see changed to the HLP framework based on your experience?
11. Any further comments about any aspect of the HLP framework and its delivery in this pharmacy?

Box 2: Interview questions for commissioners

1. What were your expectations of the HLP framework?
2. Can you describe the impact you perceive the HLP to have had on the pharmacies on the scheme?
3. Are there any aspects of the framework in general that you consider to have been a success?
4. Are there any aspects of the framework in general you consider to be barriers to its success?
5. A number of pharmacies that achieved Level 1 are not progressing on the framework to Level 2; could you outline your thoughts for why this might be?
6. What are your thoughts on health checks? Are they an important part of the framework for informing the commissioning of specific services?
7. Could you describe any feedback from the pharmacies about the HLP?
8. Is there anything you would like to see changed to the HLP framework based on your experience?
9. Any further comments about any aspect of the HLP framework?

The interview questions were designed to be balanced, to enable interviewees to express their own opinions and experiences of carrying out Level 1 of the HLP framework. Ultimately, the questions invited the pharmacists and HLCs to describe the particular successes and barriers of the framework, based on their experience of framework delivery. Each interview was carried out in a location chosen by the participant and lasted approximately 30 minutes. Interviews were conducted up until the point of data saturation when no new themes were emerging.

All interviews were recorded using a digital voice recorder and subsequently transcribed verbatim. The typed transcript was reviewed by the interviewer and compared with the field notes made during the interview to ensure meaning had not been lost in the transcription process. Interviews were analysed using a thematic approach. This method of analysis captures patterns of responses within the data set.[11] The following stages were undertaken: familiarisation with the data by re-reading of the transcripts; generating initial codes, searching for themes; reviewing themes, defining themes and reporting themes. This process was led by the primary researcher, but was reviewed by the research team who, discussed and confirmed coding and interpretation during regular project meetings. The project was approved by Durham University Geography Department Ethics Sub-committee; all participants gave informed, written consent, prior to the interview.

Results

'Providers': the benefits of the HLP

There were many aspects of the HLP framework that the service 'providers' (community pharmacists and HLCs) were positive about, namely: workforce

development, engagement (particularly with the smoking cessation service), and as a motivation for pharmacy teams. Both pharmacists and HLCs reported very positive experiences of the workforce development and capacity elements of the HLP framework. In particular, the training for the HLCs, the Royal Society of Public Health (RSPH) Level 2 Understanding Health Improvement award, was appreciated as it brought knowledge and expertise to non-pharmacists, meaning that more members of the pharmacy team are able to answer questions and distribute knowledge: *'Training has been beneficial…everyone has gained something for career development'* (Pharmacist from HLP 6).

There was also a positive theme that the HLP framework had been beneficial to engagement and accessibility with pharmacy users. Many pharmacies described becoming more proactive in approaching people with health promotion since joining the HLP framework. This was thought to be due to the combination of training, which increased the knowledge and expertise of staff at pharmacies, and the health promotion zone, which roused interest and stimulated questions: *'It has definitely positively affected engagement, pretty much everyone is approached about something'* (Pharmacist from HLP 6).

Smoking cessation emerged strongly as the most well-used and successful aspect of the framework. When asked to describe the general successes of the framework, stop smoking was the most common response. This describes a dual benefit in that it is an effective service and it brings business revenue to the pharmacy: *'Stop smoking – it works and everybody is aware of it. It's a great professional income source'* (Healthy Living Champion from HLP 11).

Many pharmacies valued the HLP framework in that it served as motivation, encouragement and recognition that pharmacies have the potential to be far more than just dispensing hubs. A strong pattern emerged in that those, whose expectations of the HLP framework had been to offer more health promotion and a greater range of services, found that their expectations had been met. Comments made by various participants throughout the interviews included: *'helping people improve their life', 'motivate the team', 'enhance services'* and '*recognition for what we already do'*.

Barriers to implementing the HLP

However, there were areas of concern amongst pharmacists and HLCs - about low awareness, the time involved in delivery, and financial considerations. These were exemplified by the health checks element - and some of these concerns were shared by commissioners. Many pharmacies described a lack of awareness of HLP as a primary barrier to success. When asked to describe the impact of HLP Level 1 on the local community, many responded that a lack of awareness prevented people from taking full advantage of the services available at HLPs: '*Awareness is low, I don't think many of our customers know we're HLP'* (Healthy Living Champion from HLP 4).

They also stated that a significant challenge posed by the HLP framework was the extra time it demanded. When asked to describe the impact on the pharmacy workforce, many pharmacies described an increased workload due to increased administration, keeping up with promotions, performing the health checks and smoking cessation consultations, and losing staff to go on additional training courses: *'I've had to employ more people to cope with the increased workload; we are now*

overstaffed in terms of prescription volumes as we're too busy doing HLP' (Pharmacist from HLP 10).

Some pharmacists described being disappointed that the framework had not been beneficial from a business perspective. In particular, those who described their expectations of the framework to increase the number of customers were dissatisfied. Financial concerns were commonly stated as the reasoning for declining Level 2: *'There's nothing to be gained by it and in this economic climate we can't afford to lose staff for training'* (Pharmacist from HLP 4).

These concerns were most apparent in regard to the health checks – which were seen as a common barrier by both pharmacists and HLCs. The issues were threefold: firstly, giving up the time to perform them; secondly, recruiting enough people to reach the target of 60 full health checks; and, thirdly, significant problems with IT needed to undertake the checks. Conducting the health checks was another common reason stated by pharmacies for not continuing to Level 2 of the framework: '*Delivering them is fine; recruitment is difficult. Our footfall for opportunistic people is low. All our regulars are on medication and so don't qualify'* (Pharmacist from HLP 6).

Commissioners also raised concerns about the very concept of health checks, with reference to the literature demonstrating no evidence of health checks reducing mortality or morbidity: *'It's a mandated service, it's written into law…so whatever I think of it, I have to commission a programme…I'd like them to disconnect the HLP framework from the health checks programme, I think they should be separate'* (Commissioner D).

The interviews with commissioners also highlighted other barriers – on the commissioning side - most notably a lack of cohesion between commissioners and service providers and a poor understanding of the broader framework. The aspirations of commissioners were narrowly focused only on the specific aspect they commissioned *e.g.* increasing smoking cessation numbers. There was little connection with the different priorities held by pharmacy staff, whose aspirations were to promote health more generally through their pharmacy as well as increase business.

In terms of understanding of the broader framework, it became clear that the commissioners only had knowledge about the specific aspect they were commissioning, and generally had a poor understanding of the wider framework. For example, when asked to comment on the general successes of the framework, none of the commissioners felt well enough informed to offer any comment. This suggests that those commissioning individual aspects of the framework do not have a holistic perspective on HLP, and therefore cannot appreciate fully the pressures and needs of those delivering it: *'Because I'm not involved in the rest of the framework and haven't had any information shared I don't know'* (Commissioner A).

Discussion

Our study identified four main benefits – as perceived by the providers – arising from the HLP framework, indicating that although these benefits are largely intangible, the HLP framework appears to be a valuable one. The commissioners did not replicate these themes, although when it came to identifying barriers toward implementation there was commonality amongst themes. Firstly, improvements to the development and capacity of pharmacy workers were reported, resulting from the training carried out through the HLP framework. Secondly, this study identified that engagement

between pharmacy workers and pharmacy users has improved, due to increased knowledge and expertise of staff, and by virtue of the wider range of services available at HLPs. Thirdly, by becoming a HLP, this process had motivated and encouraged pharmacy teams. And finally, providers also perceived the smoking cessation service as a valuable aspect to the HLP framework. This supports previous research that has shown smoking cessation services delivered in a community pharmacy setting can be valuable. These findings align with the trajectory of community pharmacy playing a key role in delivering public health services and supports previous work that showed HLPs have a positive impact on service development and staff training.[5]

We also found several barriers to the framework – both in terms of the overall implementation and in progression to Level 2. Indeed, the providers identified a lack of financial reward and the time required to deliver the services associated with the framework as barriers. Similarly, Mackridge and colleagues also identified fluctuations in funding and increased workload as barriers toward delivering an alcohol identification and brief advice (IBA) service in a community pharmacy setting.[12] Our work, although not directly associated with delivery of an IBA service, supports these findings. Another barrier identified in our study was due to the perceived lack of awareness of the HLP framework by the general population. This lack of awareness may not only impact on the number of patient's receiving services, but also on the monetary outcomes the community pharmacy receives for offering the framework. Providers reported this as a reason for not progressing to Level 2 of the framework. If the HLP framework is to improve the health of more people there should be a campaign – possibly through the local and national media – to raise public

awareness in the service. Another reported barrier for not progressing to Level 2 of the framework was the health checks. Many community pharmacies – particularly those located in areas of high deprivation – struggled with recruitment, and the time-consuming nature of delivering them. At present, at Level 1 of the framework, each HLP has to undertake 60 full health checks. This can be challenging depending on the patient demographic using the community pharmacy. Indeed, one pharmacist commented that the majority of the patients using the pharmacy were ineligible for the checks because they already have established heart disease. The commissioners also raised concerns about the health checks: one described feeling '*torn*' about the health check service, and that it should be '*separated*' from the HLP framework. This finding is timely as the effectiveness of health checks have been recently under debate; a recent review showed there is no evidence to support them.[13] However, despite the lack of robust evidence of effectiveness, health checks are still incorporated into healthcare policy throughout the UK. In many cases, it is possible the emotive rhetoric of individual success stories dominate the views of health check advocates; distinctions must therefore be made between 'good evidence' and 'good stories'.[14]

While we believe our results are robust and have important implications for the future commissioning of the HLP framework, we acknowledge that providers and commissioners were interviewed from only one region in the North of England and that this is a small-scale qualitative study. Generalisation of this work to other regions of the UK and more widely should therefore only be made carefully.

Conclusion

The HLP framework was perceived as valuable by providers and appeared to develop the workforce, which in turn, motivated the wider pharmacy team to approach patients about their health. However, there were areas of concern amongst implementation. A key barrier to the framework – perceived by both providers and commissioners – was the implementation of health checks. This should be considered in future commissioning.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of Interests

The authors declare that they have no conflicts of interest involving the work under consideration for publication, have no relevant financial activities outside the work being considered, and have no other relationships or activities that readers could perceive to have influenced the submitted work

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